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# World AIDS Day 1999

**Start Communicating about HIV/AIDS**

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The theme for this World AIDS Day on December 1, was "AIDS – End the Silence Listen, Learn, Live!" Open communication about HIV/AIDS, especially among those under age 25, is so important because for too long there has been a silence surrounding this disease. Many people are embarrassed to talk about the behaviors that can lead to HIV infection. Some believe that talking about HIV prevention with youth will lead to experimentation with sex and drugs. The truth is that this disease has deadly consequences. In the United States, an estimated 40,000 people each year are infected with HIV.[1] In 1997, among Kentuckians age 25-44, AIDS was the seventh leading cause of death.[2]

While all Kentuckians should become familiar with the behaviors that could spread HIV infection (See insert, "What you should know about HIV/AIDS"), physicians and other health care professionals have a unique opportunity to inform their patients about these behaviors and what preventive measures should be taken. In order to properly discuss issues pertaining to HIV/AIDS, one must be informed about the impact of HIV/AIDS on Kentuckians. A brief overview of the HIV/AIDS epidemic in Kentucky follows, as well as information on the state and federally funded services for those persons living with HIV/AIDS.

At the start of the 21st century, HIV and AIDS continue to impact the health of Kentuckians. Since the first AIDS case was reported in 1982, there have been 2,970 Kentuckians reported with AIDS, of which 1,385 are still living. Additionally, 2,514 persons are living with HIV who have not progressed to AIDS. Data for this article are current as of June 30, 1999.

**According to state regulation 902 KAR 2:020, Section 7, physicians, hospitals, laboratories, counseling and testing sites, and health professions licensed under KRS chapters 311-314 are required to report the name, demographics and mode of exposure of AIDS cases to the Department for Public Health within five business days of diagnosis. Health providers also are required to report HIV cases; however, only initials identify the name of the HIV case. As a result, duplicates may exist in the data set. Another limitation to the HIV data set is the high number for which the mode of exposure, year of diagnosis, age at diagnosis, or race is undetermined. Due to these HIV data limitations, this article will depend primarily on AIDS data.**

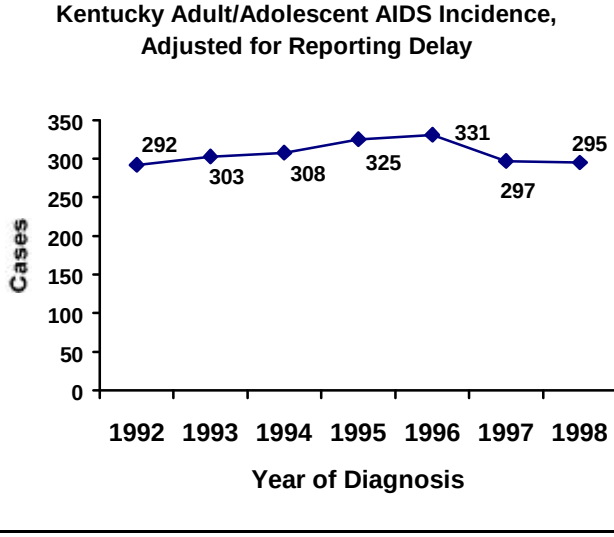
***Inside This Issue***



## GENERAL TRENDS

**Although still a threat to Kentuckians, the AIDS epidemic has changed in the 1990's.** AIDS incidence has declined recently not only in Kentucky but throughout the nation. As presented in Chart 1, AIDS incidence among adults and adolescents increased through 1996, but then dropped 10% from 1996 to

**Chart 1**



# World AIDS Day 1999, Continued

1997**.**

**In 1996, the number of Kentucky AIDS deaths declined for the first time.** AIDS deaths dropped 29% from 1995 to 1996, and AIDS deaths have continued to decline through 1998. This decline in AIDS deaths and incidence is partially due to advances in antiretroviral drugs and treatments for opportunistic infections. While these treatments have extended the life of many patients as well as lengthened the time from HIV infection to AIDS, their prolonged effects are unknown. The success of these treatments usually involves taking many pills a day on a very strict regimen. Strict adherence to these complex medication schedules is very important because if the schedules are not followed, multi-drug resistant strains of HIV may develop.

**Although deaths are declining, AIDS continues to be a leading cause of death for Kentuckians and the entire nation.** In 1997, AIDS was the twenty-first leading cause of death in Kentucky. This is a small decline from 1996 when AIDS was ranked twentieth. In 1997, among the 25-44 age group, AIDS was the seventh leading cause of death for all Kentuckians and the fourth leading cause of death for African-American males.[2] Nationally, in the same 25-44 age group, AIDS ranked second as the cause of death for all Americans and first among African-Americans.[3]

**As AIDS incidence and deaths have declined, the number of Kentuckians living with AIDS (e.g. the prevalence of AIDS) has increased 18% from 1997 to 1998.** The prevalence of those persons living with HIV who have not progressed to AIDS also increased 4% during the same time period**.**

**Many persons with HIV and AIDS may need financial assistance for drugs, housing and other necessities. In one study, the cost associated with AIDS treatment was estimated between $3,274 to $4,087 a month.[4]** The beneficial programs provided by state and federal funds must continue and need to be adapted to assist additional persons so that quality years of life will be extended. For an explanation of all state and federally funded HIV/AIDS services for Kentuckians, please see the insert titled "Overview of Services Available through Kentucky's Ryan White and State-Funded Services Programs."

- All incident rates in this article are adjusted for reporting delays.

## CHARACTERISTICS OF THE HIV/AIDS EPIDEMIC

### Gender

Not only are general Kentucky AIDS trends changing but also the characteristics of those affected are changing. The percentage of female AIDS cases diagnosed has increased from 11% in 1992 to 18% in 1998. Males, however, continue to represent a sizable majority of cumulative HIV/AIDS cases with 88% of total AIDS cases reported and 78% of HIV cases reported. The 1998 incidence rate of AIDS among adult/adolescent males at 16.5 per 100,000 population is approximately eight times higher than the rate for females.

### Racial Disparity

Whites comprise the majority of cumulative HIV and AIDS cases at 60% and 71%, respectively. However, African-Americans are affected far more disproportionately. For instance, in 1997, African-Americans comprised 7% of the total population, yet in 1998 35% of AIDS cases and 36% of HIV cases were African-American. This discrepancy has increased in recent years. The percentage of African-American AIDS cases has increased from 24% in 1992 to 35% in 1998. Also, in 1998, the adult/adolescent AIDS incidence rate among African-Americans, 46.5 per 100,000, was approximately eight times higher than the rate for whites. The high percentage of AIDS cases among African-Americans possibly relates to poor access to health care and other economic disadvantages. Race or ethnicity alone does not make one more susceptible to HIV infection.

African-Americans are not the only racial group disproportionately affected by HIV/AIDS. AIDS among the Hispanic population has shown a recent increase. From 1982 to 1996, the greatest number of Hispanic cases diagnosed in a single year was 6. In 1997, 11 Hispanic AIDS cases were diagnosed. A similar but more gradual increase is also noted among HIV cases. The Hispanic adult/adolescent AIDS rate for 1998 at 33.2 per 100,000 population is approximately five times higher than the rate for whites. As the Hispanic population increases in Kentucky, added emphasis should be placed on their possible health needs.

### Age at Time of Diagnosis

Among those diagnosed with AIDS in 1998, the highest percentages were in their thirties. The HIV percentage in the 30-39 age group (34%), however, is less than the AIDS percentage in the same age group (48%). The percentage of those with AIDS diagnosed in their teens and twenties has remained relatively stable in recent years; however, their percentages have increased among HIV cases.

### Mode of Exposure

Persons are infected by HIV primarily through sexual exposure or contact with blood infected with HIV, such as

# World AIDS Day 1999, Continued

**Chart 2**

**Kentucky 1998 AIDS Cases by Age at Time of Diagnosis, 6/30/99 ***

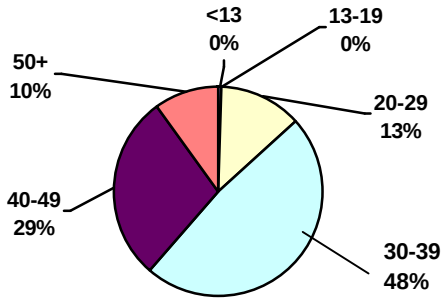
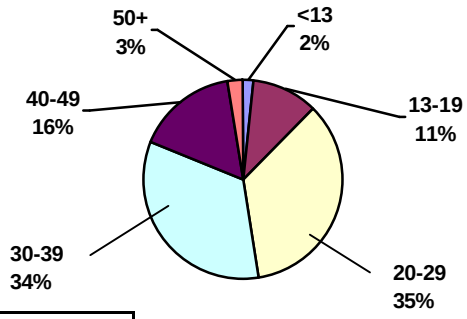



**Chart 3**

**Kentucky 1998 HIV Cases by Age at Time of Diagnosis, 6/30/99 ***




*Percentages may not total 100% due to rounding.

by injecting drugs with a contaminated syringe. Mothers also can pass HIV on to their children perinatally, during pregnancy, birth, or through breastfeeding.

Men who have sex with men (MSM) comprise the majority of Kentucky's male adult/adolescent HIV and AIDS cases, 63% and 58%, respectively. However, the percentage of MSM AIDS cases has declined in recent years. Among male AIDS cases in 1998, the second highest risk factor was injecting drug use (IDU) 13%, followed by heterosexual contact, 10%, and the combination risk factor MSM & IDU at 6%. In the 1990's, male AIDS cases attributed to IDU and heterosexual contact have increased.

Among adult/adolescent females in 1998, the greatest percentage of HIV cases at 72% and AIDS cases at 41% was attributed to heterosexual contact. The second highest percentages of female HIV and AIDS cases are attributed to injecting drug use. Cases related to both risk factors have remained relatively stable in recent years.

**Chart 4**

**1998 Adult/Adolescent Kentucky AIDS Cases by Mode of Exposure, 6/30/99 ***

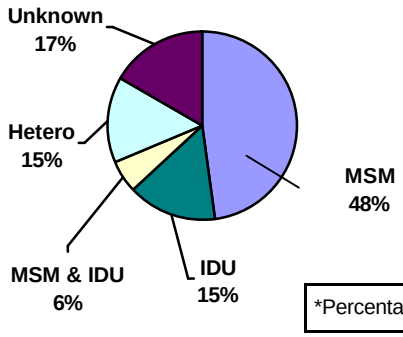
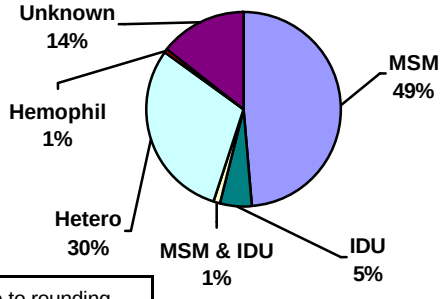



**Chart 5**

**1998 Adult/Adolescent Kentucky HIV Cases by Mode of Exposure, 6/30/99 ***




*Percentages may not total 100% due to rounding.

The percentage distribution by mode of exposure of all adult/adolescent AIDS and HIV cases diagnosed in 1998 is presented in Chart 4 and Chart 5.

Kentucky has had very few AIDS cases resulting from perinatal transmission. The greatest number of perinatal AIDS cases, 5, was diagnosed in 1996. Since that time cases have declined with only one perinatal AIDS case diagnosed in 1998 and one case diagnosed so far in 1999. The Centers for Disease Control and Prevention and the American Academy of Pediatrics have both recommended HIV counseling and testing of pregnant women.[5,6] In 1998, an Institute of Medicine report also emphasized the need for HIV testing of all pregnant women.[7] *Early detection of HIV among pregnant women is so important because studies have shown that administering the drug AZT to the mother*

# World AIDS Day 1999, Continued

*during pregnancy and birth and to the infant for six weeks after birth reduces the risk of HIV transmission by two-thirds.*

The number of Kentucky persons with AIDS cases who contracted the disease through tainted blood, blood clotting products and transplants has declined since 1992. Only two HIV cases in this category have been diagnosed since 1996. This is due to better screening of blood products and transplants starting in 1985. There have been no occupationally related HIV or AIDS cases reported in Kentucky.

**Geographic Distribution**

Although persons with HIV and AIDS have resided in every Kentucky Area Development District (ADD), most persons are from metropolitan areas. In 1998, the majority of AIDS cases at 47% resided in the ADD that contains Jefferson County and the city of Louisville; 41% of cases resided in Jefferson County at the time of diagnois. This ADD also had the highest AIDS rate of 12.3 per 100,000. The ADD with the second highest percentage of AIDS cases at 15% was Bluegrass. Fayette County and the city of Lexington are located in this ADD. Prevention efforts and HIV services programs must continue to target the high prevalence areas of the state while still providing culturally appropriate resources to more rural areas.

**CONCLUSION**

- HIV and AIDS continue to be serious public health problems, although AIDS incidence and deaths have declined in Kentucky and throughout the nation. As more people are living with HIV and AIDS, medical, financial, and other support services must be maintained and developed in order to extend quality years of life.
- Prevention efforts targeting those at high risk for HIV infection also must continue. These initiatives must be racially sensitive and incorporate differences in gender, age, and economic status.
- Emphasis on early HIV testing is an important component of HIV of prevention efforts. HIV testing counselors educate HIV positive clients about ways to prevent infecting others, and educate HIV negative clients about ways to avoid infection in the future.
- The goal of World AIDS Day was to end the silence surrounding HIV disease. A special effort must be made to discuss HIV/AIDS related issues with family members, friends, co-workers, clients, and patients. Whether the topics are the advantages of early HIV testing, how to prevent HIV infection, or the impact of HIV on the state and nation, it is imperative to start communicating about HIV/AIDS. This communication is important because silence can lead to misunderstanding, complacency, and even death.

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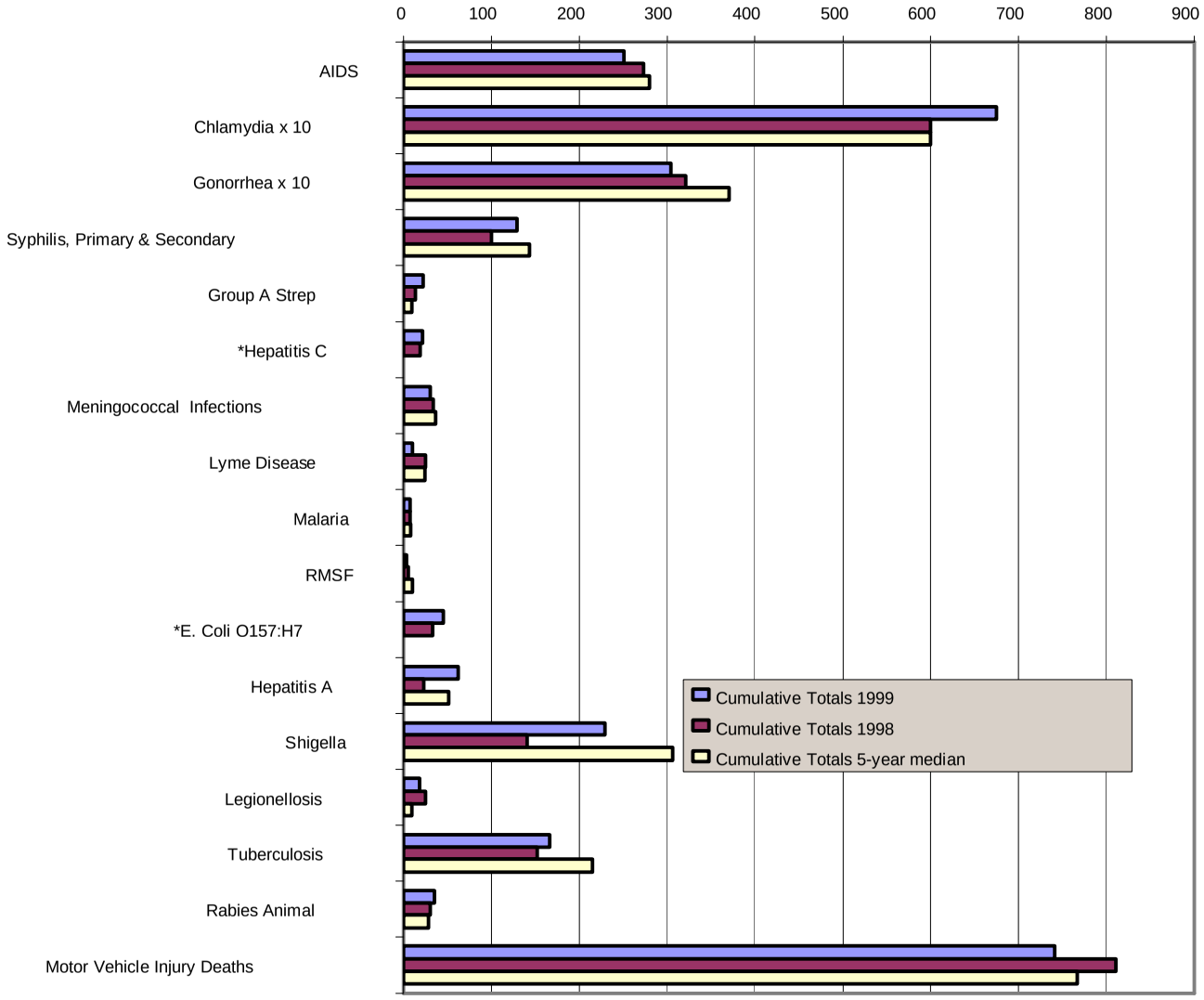
**CASES OF SELECTED REPORTABLE DISEASES IN KENTUCKY, YEAR TO DATE (YTD)**
**THROUGH NOVEMBER 1999**




| Vaccine Preventable Diseases | | |
|---|---|---|
| **Diseases** | **1999 YTD** | **1998 Annual Totals** |
| **Diphtheria** | **0** | **0** |
| ***Haemophilus influenzae b*** | **7** | **7** |
| **Hepatitis B** | **42** | **44** |
| **Measles** | **2** | **0** |
| **Mumps** | **0** | **1** |
| **Pertussis** | **25** | **93** |
| **Polio** | **0** | **0** |
| **Rubella** | **0** | **0** |
| **Tetanus** | **0** | **0** |

*Historical data are not available.
Disease numbers reflect only those cases which meet the CDC surveillance definition.
Contributed by: Patricia Beeler, Surveillance and Health Data Branch.

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# VACCINE ALERT

## ROTAVIRUS VACCINE WITHDRAWN

**During recent months, the adverse side effect of intussusception attributed to the Rotavirus vaccine (Rota Shield) has placed its use in question. Intussusception is a form of bowel obstruction caused by a portion of intestine prolapsing into an adjacent section of intestine.**

In the United States, Rotavirus is the most common cause of severe diarrhea in children 5 years of age and under. The fecal-oral route is the major mode of transmission for this highly infectious virus. This illness accounts for 50,000 physician visits and 50,000 hospitalizations a year.

When Rotavirus vaccine became available, ACIP guidelines recommended administration at 2 months, 4 months, and 6 months of age. Twelve cases nationally of intussusception among children who had received the rotavirus vaccine were reported to the Vaccine Adverse Events Reporting Systems by June 16, 1999.

On July 16, 1999, Wyeth Lederle (Rota Shield developer) temporarily suspended distribution and administration of the Rotavirus vaccine until further investigation on the connection between the vaccine and intussusception could be reviewed.

On October 22, 1999, the Advisory Committee on Immunization Practice (ACIP) concluded that intussusception occurs with significantly increased frequency in the first 1 – 2 weeks after vaccination with the Rotavirus vaccine, particularly following the first dose. At that time **ACIP no longer recommended vaccination of infants in the United States with Rotavirus vaccine and withdrew its recommendation for subsequent administration of the vaccine at 2, 4, and 6 months of age.**

**Children who received Rotavirus vaccine before July and have remained well, are <u>NOT</u> now at increased risk of intussusception.**